FSD-097 (10/2014) MICHIGAN STATE POLICE, Forensic Science Division

Page 1 of 10

AUTHORITY: MCL 333.21527, MCL 752.933-752.935 **COMPLIANCE:** Voluntary

		PATIEI	NT/EXAMINER INF	FORMATION
Patient Address				MR/Case Number:Phone Number:Contact Number:
Date of	Birth: _	Age:	Sex:	Contact Instructions:
Date of	Examinati	ion: Time of Exam	nination:	Ethnicity/Race:
A. Info	rmation	for Patient (Health provider rev	iew with patient)	
	Patient h	nas signed appropriate consent for t	reatment provided by th	ne health provider (not included here).
		ent has been told that she or he is nent as a condition of receiving trea		te in the criminal justice system or cooperate with law collection.
		understands that receiving an exam any point in time and still receive m		ence collection is voluntary and that she/he may stop the atient chooses.
	The patie	ent has received a copy of the book	det "Important Health II	nformation for You" (provided in evidence collection kit).
	Informati collection	_	amination payment option	ons has been explained to the patient (provided in evidence
			MEDICAL HISTO	DRY
		dical History		
Current	Medicatio	ons (including contraception):		
General	Medical I	History:		
		History:		Last Tetanus Immunization:
Disabilit	y: □No	□Yes, comments:		
Recent	treatment	s, including last OBGYN exam, des	cribe:	
Surgerie	es, proced	lure/date:		
				evious 6 months? No Yes Date:
Consen	sual coitu	s in last 120 hours? □No □Yes	If yes, condo	muse? □No □Yes □ NA
C. Hist	ory of C	hief Complaint/Assault		
Date of	Assault: _		Time of Assa	rult:
Brief His	story of As	ssault (include loss of memory or la	pse of consciousness a	nd/or alcohol/drugs used):
	2			
				·

Page 10 of 10

O. Authorization for Release to Law Enforcement or Storage Without Release to Law Enforcement

INFORMATION ABOUT RELEASE FOR PATIENTS (Health provider review with patient)

- You do not have to sign this release and you are not required to release the evidence collection kit, information, or other items listed below.
- You have the right to revoke this release at any time, provided you do so in writing to the health provider listed below. However, once the evidence collection kit, information, or other items listed below have been transferred to law enforcement, the health provider can no longer get them back.
- If you decide to release the evidence collection kit and information listed below, it can be reviewed by the law
 enforcement agency, the prosecuting attorney, the Michigan State Police Forensic Laboratory, or other accredited
 laboratory. These organizations are not health care providers covered by federal health privacy laws and are
 governed by other laws.
- If you decide not to release the evidence collection kit, the health provider is required to store the evidence collection kit for a minimum of one year. However, under very rare circumstances the health provider may be required by law to release the evidence collection kit to law enforcement without your permission (for example, in response to a court order).
- You may ask the health provider to inspect or receive a copy of any records disclosed under this authorization.

АГ	PATIENT WISHES TO RELEASE THE EVIDENCE COLLECTION KIT AND SELECTED ITEMS
^ 	(Patient Initials)
	I,, authorize(Name of Patient) , authorize(Name of Health Provider Completing Exam)
	(Name of Patient) to disclose and release the following items noted below with my initials for the purposes of criminal investigation and to assist in the prosecution of the person or persons responsible for the crime. This authorization expires one year after the date of release. Items released to the below recipients during that one year period can be used until the final adjudication of the criminal case.
	I authorize the release of the following information and items: (patient initial each)
	Evidence collection kit contents
	Urine and/or blood for toxicology
	Photographs
	Clothing/Other
	 Law Enforcement Agency (name of agency if known): Prosecuting Attorney's Office for County of (name of county if known): Michigan State Police Forensic Laboratories or Other Appropriate Accredited Laboratory
	OR
В с	PATIENT DOES NOT WISH TO RELEASE THE EVIDENCE COLLECTION KIT AT THIS TIME
	If you decide to release the evidence collection kit prior to the above date, you should contact (instructions for
	contacting Provider):
SIGNA The sabov	signature below documents my intent to release or not to release the information and items listed in sections A or B
Patie	nt Signature Date
Pare	nt/Guardian Signature (if required)Relationship
Witn	ess Signature Date

White—Medical Records Yellow—Place in Kit Pink—Law Enforcement Goldenrod--Patient